

---

State Child Fatality Review Report  
SFY 04-05  
G.S. 143B-150.20

---

Family Support and Child Welfare Services Section  
Division of Social Services  
NC Department of Health and Human Services

2005

**State Child Fatality Review Report to the  
North Carolina General Assembly**

**Table of Contents**

**Executive Summary**

**I. History**

**II. Review Process**

**III. Facts Regarding State Child Fatality Review Process**

**IV. Fatality Reviews/Major Themes SFY 04-05**

- A. Inconsistent Compliance with Policy and Best Practice Issues**
- B. Legal/Criminal Issues**
- C. Community Child Protection Team Enhancement**
- D. Mental Health Services for Families**
- E. Medical Services for Families**
- F. Safe Sleeping**
- G. Compliance with the Reporting Law**

**V. Conclusions**

**VI. Appendices**

**State Child Fatality Review Report**  
**SFY 04-05**  
**Executive Summary**

Pursuant to North Carolina General Statute 143B-150.20, the Department of Health and Human Services, Division of Social Services, has the responsibility to convene a State Child Fatality Review Team to “conduct in-depth reviews of the child fatality which occurred involving children and families involved with local Departments of Social Services child protective services in the 12 months preceding the fatality.” The purpose of these reviews is to “implement a team approach to identifying factors which may have contributed to conditions leading into the fatality and to develop recommendations for improving coordination between local and State entities which might have avoided the threat of injury or fatality and to identify appropriate remedies.” The Statute specifies team membership that includes representatives from the Division of Social Services, the county department of social services (DSS), the local Community Child Protection Team (CCPT), the local Child Fatality Prevention Team (CFPT), local law enforcement, a medical expert, and a prevention specialist.

The reviews consist of interviews with selected individuals and reviews of case records of the county DSS and other agencies that provided services to the child and family. The process focuses attention on the role and involvement of the broader community in protecting children. A formal report is issued at the conclusion of each review that includes the findings and recommendations from the State Child Fatality Review Team. The team presents these findings and recommendations in a public meeting of the Community Child Protection Team. The written report is available to anyone who requests it. Following the issuance of each report, Division of Social Services staff present the recommendations that have statewide impact to the State Child Fatality Prevention Team in an effort to identify the most appropriate state level entity to follow up on each state level recommendation.

During SFY 04-05, 40 final fatality review reports were issued following completion of the reviews, 24 reports issued were on deaths that occurred prior to SFY 04-05. During the year, the Division of Social Services identified 60 (31%) child fatalities that met the criteria for a State Child Fatality Review Team review out of 192 deaths reported. Out of the 60 deaths, neglect was suspected to have contributed to the fatality in 43 cases and abuse was suspected in 17 cases.

For the reviews conducted during the year, the review teams identified seven major themes. First, the review teams identified the need for the local Department of Social Services (DSS) to improve in the area of compliance with policy and best practice. In an effort to assist local DSS agencies with improvement, there were a variety of recommendations made for the NC Division of Social Services and local DSS agencies. Secondly, legal issues were prevalent during this period for reviews. This particular theme involved judges, law enforcement and attorneys. There were areas where legal issues were not being thoroughly addressed and/or timeliness was a concern. The third major theme involved the need for Community Child Protection Teams (CCPT's) to take a proactive and a more direct role in the community and with DSS agencies. This also involves CCPT's becoming better advocates regarding services for families and children. The fourth major theme is in the area of Mental Health Services for families. At times, these services are unavailable, in addition not tailored to meet the needs of each individual. The fifth major theme is in the medical area, to include the need for improved collaboration between medical professionals and DSS staff; the need for establishing protocols and procedures between these two entities; and the need for medical services designed to support children with special needs. Safe sleeping deaths have emerged at an alarming rate and comprise the sixth major theme. Finally, non-compliance with the reporting law is another major theme. Additional themes and issues were identified and are listed in Appendix A to this report. Appendix B lists accomplishments by local communities as a result of recommendations from reviews.

## **State Child Fatality Review Team Annual Report**

Pursuant to G.S. 143B-150.20, following is the State Child Fatality Review Team annual report to the N. C. General Assembly for SFY 04-05. This report includes a summary of findings and recommendations of child fatality reviews conducted by the State Child Fatality Review Teams during SFY 04-05. These teams conduct multidisciplinary reviews when there is suspicion that neglect or abuse caused a child's death and the county DSS children's services program was involved with the child or family any time in the previous year.

### **I. History**

In 1997, the General Assembly enacted G.S. 143B-150.20 and established the State Child Fatality Review Team to conduct in-depth reviews of any child fatalities which have occurred involving children and families involved with local departments of social services child protective in the 12 months preceding the fatality.

The collaborative, multi-disciplinary approach to these reviews, along with information available to the public through the review reports, make these reviews learning tools for the entire community. These reviews provide information to improve efforts to prevent future child deaths.

Feedback from those involved with State Child Fatality Review Teams has been that there is ownership by the local communities with Review Team recommendations and commitment to implementation of the resulting action plans. The State Child Fatality Review Teams have implemented six-month follow-up contacts with the local Community Child Protection Teams (CCPT's) after a review is completed. These follow-up contacts with the CCPT's focus on the progress at the local level in implementing any systemic changes as a result of the recommendations from the Review Team.

### **II. Review Process**

Currently, child fatality reviews are conducted as follows:

- A. By State law, anyone who has cause to suspect that a child has died as the result of maltreatment must report the case to the director of the county Department of Social Services (DSS).
- B. The DSS reports to the Department of Health and Human Services, Division of Social Services (the Division) information that they receive regarding any child who is suspected to have died as a result of maltreatment.
- C. The Division determines whether the necessary criteria are met to invoke a review by a State Child Fatality Review Team based on information from the county DSS and any local law enforcement or health care professional who was involved in investigating the child's death or the death scene.

- D. A State Fatality Review Team is convened, including representatives of the Division of Social Services, the county DSS, and representatives from the local Community Child Protection Team, the local Child Fatality Prevention Team, local law enforcement, a medical expert, and a prevention specialist.
- E. Division staff on the team begins all reviews with an introduction about the review process to all participants.
- F. The review consists of interviews with selected individuals and reviews of case records of the county DSS and other agencies that provided services to the child and family. The process focuses attention on the role and involvement of the broader community in protecting children.
- G. The team writes a report that includes the findings of the review and recommendations for system improvement.
- H. The team presents these findings and recommendations in a public meeting of the Community Child Protection Team. The written report is available to anyone who requests it.
- I. As each State Child Fatality Review Report is completed and released, Division staff present recommendations that have statewide impact to the State Child Fatality Prevention Team in an effort to identify the most appropriate state level entity to follow up on each recommendation. For recommendations that need to be addressed by the Division, a work group established in the Family Support and Child Welfare Section (FSCWS) examines the issues identified and presents the recommendations to the FSCWS Management Team for any necessary action.

### **III. Facts Regarding State Child Fatality Review Process**

The State Child Fatality Review process is an ongoing one, and there is on occasion overlap with child deaths and the reports from one fiscal year to the next. For example, a child death and State Fatality Review is conducted during one SFY, but the actual report is not issued until the next SFY. Therefore, reviews conducted and reports issued include fatalities that were reported to the Division and decisions to conduct reviews from the previous fiscal year as well as those from the current fiscal year. Some of the cases identified in the current fiscal year will be reviewed in the next fiscal year. During SFY 04-05, 40 final fatality review reports were issued following completion of reviews, 24 reports issued were on deaths that occurred prior to SFY 04-05 .

The State Division of Social Services identified 60 child fatalities (out of 192 deaths reported) in 39 counties that met the criteria for a State Child Fatality Review Team review during SFY 04-05. To meet the criteria for a State Child Fatality Review, there had to be a suspicion that abuse or neglect was a factor in the fatality. In addition, the child or family must have been involved with a county Department of Social Services (DSS) child protective services in the 12 months preceding the fatality. Of these 60 child deaths, neglect was suspected in 43 cases and abuse was suspected in 17 cases.

#### **IV. Fatality Reviews/Major Themes SFY 04-05**

The State Child Fatality Review Teams often identify similar issues in the cases that they review. At other times, there may be a major issue identified that had not been noted previously but that has statewide impact. Other findings are more case specific or community specific.

The seven most commonly identified major findings and lessons learned from the 40 child fatality reviews completed during SFY 04-05 are summarized here so that the North Carolina Division of Social Services, County Departments of Social Services, and other state and county agencies can make systemic improvements focused on the safety of children. Also, in these seven areas is information on what North Carolina has done thus far to address many of the issues identified during the review period. Achievements at the state level related to these findings are noted where relevant at the time the individual fatality reports were issued. Appendix A reflects recommendations that were identified less often or that were more case-specific but that were still important recommendations that should be considered statewide. Appendix B reflects achievements at the local level that have resulted from recommendations from State Child Fatality Reviews.

##### **A. *Inconsistent Compliance with Policy and Best Practice Issues***

In many of the fatalities reviewed, the review teams identified the need for thorough child protective services investigations and assessments. In a number of the reviews, the allegations were not thoroughly assessed nor was sufficient contact with the family, children or persons who had knowledge about the family maintained to assess the level of risk in families. These steps are an integral part of a thorough assessment and can lead to tragic outcomes if not completed. A thorough assessment begins at the intake process and does not end until the risk to the children is sufficiently reduced and the case is closed by DSS.

It is important to note that staff turnover and high caseloads were found to be contributing factors in many situations that involve lack of compliance with policy; in addition, when there were shortcomings in the area of best practice. In an effort to address these issues the North Carolina General Assembly recently appropriated \$2 million dollars to the Division for the purpose of hiring additional child protective services workers at the local level. The intent of the General Assembly in appropriating these funds is to reduce the caseload ratios per child protective services worker in order to support the expansion of the Multiple Response System to all 100 counties.

The Children's Service Manual, Chapter 8, Section 1407 "Structured Intake" and Section 1408 "Receiving and assessing reports of abuse, neglect or dependency" guides decision making and practice regarding assessing child protective services intake reports and a thorough assessment of all factors present within a family. Using a holistic approach in identifying family's strengths and needs is crucial to providing a thorough assessment of any and all risk factors and safety.

Several reviews identified the need to research internal agency history to assist with identifying patterns during the intake process. Access to Administrative Office of the Courts (AOC) records has been beneficial in assessing criminal activities and how they may impact on the safety and well being of children. As recommended during last year's review, access has been expanded to all 100 counties to aid in the assessment of risk to children. The Division of Social Services is exploring the idea requiring criminal record searches as a part of completing a thorough assessment.

Collaboration within DSS, cross county and across state lines continues to be a barrier. Several reviews indicated that communication between internal departments of DSS should enhance services to families. This communication includes child and family team meetings to collaborate and communicate with family members and service providers, discussions with licensing workers prior to placement of children in foster homes and then ongoing monthly communication to address additional needs, and joint home visits when cases have been transferred across county lines. DSS continues to struggle with ensuring children are safe and services are provided when families move across county and state lines.

***B. Legal/Criminal Issues***

Law Enforcement agencies provide a vital role in the protection of children; therefore, strong collaboration between the Department of Social Services and law enforcement agencies is necessary. Of the forty reports issued, fifteen cases have recommendations surrounding or involving law enforcements agencies in eleven counties. Several reviews indicated a need to strengthen the laws surrounding child deaths related to abuse or neglect, to charge parents when crimes are committed and children are involved and to actively pursue felony murder charges when parents or caretakers murder their children. Legislation should be introduced addressing leaving young children alone in cars

Unfortunately law enforcement agencies are not always notified when a child dies of unnatural or unexpected causes. When no notification is given, it prevents a thorough investigation which includes securing the crime scene and interviewing all parties that have knowledge of the death. In addition, law enforcement does not always notify the Department of Social Services of these fatalities which may leave surviving children vulnerable if the death is under suspicion.

The Office of the Chief Medical Examiner developed a pilot protocol "North Carolina Child Death Investigation Protocol" to be implemented in selected counties across the state. This provides a standardized method for conducting child death investigations. The focus is on investigations being interdisciplinary and collaborative in order for essential information to be gathered, shared and analyzed.

Additionally, recommendations that were noted in reviews include the criminal court judges being aware of DSS involvement when issuing court orders, ongoing funding for family court, and ongoing public awareness of the new law regarding car seat

restraints for children, and thorough investigations by law enforcement agencies. These issues are being addressed as a part of the North Carolina Court Improvement Project.

**C. *Community Child Protection Team Enhancement***

Community Child Protection Teams (CCPT's) and Child Fatality Prevention Teams (CFPT's) provide an opportunity for the community to come together to address issues of child safety. These teams look at system barriers, gaps in services and lessons learned. It is vital for all statutorily required members to be present at these meetings to make them effective. Poor attendance or participation only hurts the very people who need this gathering of information the most, the children. CCPT's and CFPT's are the link to the community. These teams are vital in the ongoing education of the dangers to children. Education around available resources, mandatory reporting laws, new laws effecting children, ongoing education to substance abusing pregnant mothers, substance abuse and the effects on children and advocating for much needed resources are a small fraction of recommendations from fatality reviews.

Additionally, CCPT's and CFPT's should continue to remind members on the purpose of the meetings, how to review cases, when to bring community cases to the team and gain commitments for follow up. Chronic neglect cases are those that tax DSS agencies and local communities. These cases involve little to no movement or progress, and serve as a drain on community resources. Cases of this sort are frequently the most difficult cases for DSS agencies and communities to address. These cases require a holistic assessment and a rigorous community response. At times, there is a correlation between chronic neglect and criminal activity, such as illegal drug use and distribution. These situations are often determined as an injurious environment, and can lead to on-going and chronic problems for the children.

**D. *Mental Health Services for Families***

In seven counties and eight different cases, mental health reform and the subsequent confusion of where to seek services has been a barrier. Often families have to travel out of county to seek mental health and substance abuse services. These services are limited and may not be offered as conveniently as before. Requests to re-evaluate the Mental Health Reform plan and how it is being implemented at the local level within communities are prevalent in many fatality review reports. These requests include findings sighting lack of services and a confusing system for our families to follow and understand. When mental health services are provided, treatment team meetings are required to ensure families' and children's needs are being addressed. Meetings should occur monthly with all involved parties coming together to discuss the treatment plan, risk factors and ongoing needs. When children are in the custody of the Department of Social Services, there should be ongoing communication between the therapist and the social worker with notification to the social worker should the client miss appointments.

Local Management Entities should have access to licensure violations across county lines and should be in communication with each other when children are placed across county lines. Policies should be developed outlining their response to licensure violations and process for continued referrals and utilization of providers with violations. This information should be accessible to the consumer and the public. Additionally, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services should develop more stringent rules that provide for a provisional licensure period for mental health group homes and for staff qualifications and should ensure that sufficient Level IV and Psychiatric Residential Treatment Facilities are available to meet the waiting list need.

***E. Medical Services for Families***

Medical providers are important to the assessment of any medical concerns related to children and should be consulted whenever medical issues are in question. Social workers should not assess medical issues in isolation and should utilize tools that are in place to assist with the assessments concerning medical questions. Reimbursement rates for medical professionals conducting a Child Medical Evaluations (CME) or Child Mental Health Evaluation (CMHE) for services are not competitive and create difficulty in the recruitment and retaining of qualified medical professionals. Ongoing recruitment of medical professionals who are willing to provide these assessments is crucial. All medical concerns should be, at a minimum, discussed with a qualified professional capable of rendering a medical opinion on the injury or condition. Medical professionals should have a heightened sense of potential child abuse and neglect risk factors and should refer to pediatric specialists when in doubt.

Additionally, community resources should be utilized for high risk infants at discharge from hospitals. Parents should have a clear understanding of their infant's risk factors and have the ability to verbalize and demonstrate any special care needs for their infant. Child Service Coordination referrals should be made when risk factors are present that would warrant a referral. Child Development Services Infant/Toddler Service Coordinators should have medical backgrounds that allow them to assess medically fragile or complex children as well as developmental related disabilities. Often times, high risk infants are involved in multiple services which can make the coordination of these services difficult. Case managers would be an option to assist the primary physician in the coordination of services to families. Coordination would include scheduling appointments, transportation and verification that appointments were kept. These issues can greatly affect the quality of life for medically fragile infants and may even extend their lives substantially.

**F. *Training on Safe Sleeping Practices***

Over the past fiscal year, a substantial number of infants died as a result of suffocation, mechanical wedging, or asphyxiation in relation to sleeping patterns and practices. These deaths seem to be increasing at an alarming rate. These deaths occurred due to inappropriate bedding in cribs, children sleeping on couches with parents, or being wedged between a mattress and a wall.

Recommendations include ensuring that the Division of Social Services addresses safe sleeping practices and equipment in trainings for social workers and foster parents and collaborating with community partners to provide training to service providers that have contact with families in the home setting. Many concerns surfaced around young service providers who may not have personal experience on safe sleeping equipment. Training should be focused on how to assess and recognize safe sleeping patterns and sleeping equipment based on developmental stages of children.

The Division of Social Services already offers a variety of opportunities into which safe sleeping and safe sleeping equipment could be incorporated. Additionally, MAPP (Model Approach to Partnership in Parenting) is required by families in order to become licensed foster parents. This training could be incorporated into MAPP or as an additional in-service to foster parents.

The Health Department has an established training on safe sleeping. They, in-conjunction with the American Pediatric Society, are strong advocates of the Back to Sleep Campaign. Several recommendations from the fatality reviews are that the Division of Social Services should partner with existing agencies and support established campaigns that promote the safety and well being of infants while they sleep. At the state and county levels there should be a continuation of partnership that stresses the importance of safe sleeping of infants.

**G. *Compliance with the Reporting Law***

All citizens are responsible for reporting child abuse. North Carolina G.S. 7B-301 states:

“Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, ... or has died as a result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found.”

This year the State Child Fatality Review Teams often found that reports of suspected abuse or neglect were not made to the local DSS with tragic consequences, as in previous years. Nineteen reviews revealed many professionals and other community members did not make reports when presented with information that warranted a report of suspected abuse and/or neglect. Recommendations from the fatality review teams included the need for more training in the local communities about the requirements for reporting suspected child abuse and neglect, as well as increased public awareness campaigns on how to report such suspicions. Mental health agencies, domestic violence shelters, all hospital and emergency room staff, pediatricians, county employees, educational personnel, emergency management staff, and law enforcement agencies need to be particularly targeted for training on recognizing signs of abuse and neglect and on the requirement for reporting suspicions to DSS. One recommendation was that there should be statewide training on the aspects of reporting child abuse and neglect for professionals outside of the DSS system and for county staff in other program areas, such as Environmental Health. Another recommendation was that the Department of Health and Human Services should require all state and local agencies under the auspices of the Department incorporate in their orientation and staff training programs the aspects of reporting.

Additional clarification is needed with all first responders to child fatalities (EMS, local law enforcement, hospital emergency room staff, medical examiners) about the need to make a report to DSS when a child dies and there are surviving children in the home.

It should be noted that Children's Services Program Management Standards issued by the Division of Social Services require that all county Departments of Social Services provide regular community awareness and public education programs on recognizing and reporting abuse, neglect, and dependency. All counties provide regular ongoing community awareness and public education programs and these efforts need to continue.

In addition to local efforts, Prevent Child Abuse North Carolina has long played a vital role in raising public awareness statewide about recognizing abuse and neglect and how to report suspicions to the local DSS. This organization has thirty (30) affiliates statewide and has the goal of identifying a member or an affiliate in each community in the state. Through their Helpline (1-800-CHILDREN), they provide information and guidance to citizens on how to report suspected abuse or neglect to DSS. They also provide a Prevention Resource Center that has public education and awareness material and training curricula that is available to local CCPT's and CFPT's. Their web site is also easily accessible at [www.preventchildabusenc.org](http://www.preventchildabusenc.org). The organization is in the process of providing training across the state for local community educators, after-school personnel, and child care employees and anticipates around 1,000 individuals being trained. This training is designed for the trainees to have the capacity to return to their local communities to train others in the community on recognizing abuse and neglect and how to report.

In addition to finding that suspicions of abuse or neglect were not always reported to DSS by the community, the review teams identified related issues that involved the DSS intake process. There were several instances where someone from the community believed that they had enough information to report to DSS. Persons making a CPS report to DSS are often emotional when reporting the information that they have. Information is best received and analyzed by the intake worker if the information is as factual as possible. One recommendation was that intake workers need to ask clarifying questions when using the Structured Intake Tool to assist callers in giving specific, factual information and in defining clearly what they mean. Clear and complete information from the reporter must be documented on the intake form including all allegations of abuse and neglect that need to be addressed by the investigative worker.

The Strengths-based, Structured Intake process and tools approved by the Children's Services Committee of the North Carolina Association of County Directors of Social Services and the Division of Social Services was implemented with the effective date of June 1, 2003 for all 100 counties. Since that time, there has been evidence suggesting that with the use of these Intake tools outcomes has improved in this area. This process provides social work staff with a structured intake instrument that guides discussions with reporters and utilizes decision trees to assist with more consistent intake decisions from worker to worker and county to county. The Strengths-based, Structured Intake process is one of the seven Multiple Response System (MRS) strategies.

MRS will be able to address the many recommendations from the child fatality reviews that called for better information sharing and collaboration across agencies in serving children and families. Also, this approach provides the Division of Social Services the opportunity to build on the efforts of using family-centered principles of partnership woven throughout the seven MRS strategies to achieve North Carolina's mission of ensuring safe, nurturing and permanent families for children. During this state fiscal year, the Division of Social Services worked with 52 MRS pilot counties regarding implementation of this demonstration project. Agencies are using Child and Family Teams in CPS in-home services cases which is another strategy of MRS. Like the Family Team Decision-Making meetings in Family to Family, these Child and Family Teams bring the family together with their natural supports and community resources for planning and decision-making. The North Carolina General Assembly recently authorized implementation of MRS in all 100 counties, effective January 2006. The other five strategies of MRS are:

1. A choice of two approaches to reports of child abuse, neglect or dependency
2. Coordination between law enforcement agencies and child protective for the investigative assessment approach
3. A redesign of in-home services
4. Implementation of Shared Parenting meetings in placement cases
5. Collaboration between Work First and child welfare programs

## **V. Conclusion**

In an effort to enhance case practice and service delivery for children and families in North Carolina, there is vast amount of time, effort and resources exhausted by North Carolina's Child Fatality Review Teams, Child Fatality Prevention Team, Child Fatality Task Force, Community Child Prevention Teams, Community Child Protection Teams, the Division of Social Services, the Medical Examiner's Office and others by taking a hard look at child deaths. As a group, one main goal is to prevent child deaths, when possible. With this goal in mind, there is a great deal of attention given to 'lessons learned' in that, systemic issues including shortfalls and community/family needs must be identified and addressed in a timely fashion. The completion and sharing of this Annual State Child Fatality Report is a part of this process.

The contributions of informed state and community professionals that served on the State Child Fatality Review Teams during SFY 04-05 have made this report possible. These individuals devoted countless hours during the reviews, frequently volunteering their time without compensation. The review team members intensively reviewed the circumstances of each child's death and confirmed that protecting children is a shared community responsibility.

The findings and recommendations of these multidisciplinary teams have statewide implications. Also, it is important to note that many of these findings and recommendations involve systemic issues, multiple departments and/or agencies, child abuse/neglect cases that have increased in complexity, the need for more resources and improved collaboration between all parties. By acknowledging these major issues, it is recognized that one year is not sufficient time for the completion of goals in response to these issues. However, the efforts of all professionals and the Division of Social Services will continue with the intent of fully addressing these repeat findings and recommendations.

It is recommended that state agencies and all local communities in North Carolina use this report to examine the issues relevant to the protection of children and the prevention systems in place in order to make any improvements that are indicated. If the lessons learned as a result of a child's death can be applied in such a way as to prevent future fatalities, the state's protection of children will be significantly enhanced and the legislative intent will be met.

## Appendix A

Appendix A reflects additional recommendations that were either identified less frequently than those in the body of the report or that were case specific. Several of these recommendations were also in last year's report. However, these issues/recommendations continue to be key ingredients in North Carolina's fatality prevention efforts and have remained in this year's report. These important recommendations for North Carolina include:

### **Cross County Issues**

- The Cross County Policy was effective December 2003 and should be followed by all county DSS. In addition, the Division of Social Services should consider drafting policy to address joint home visits when cases are transferred and counties are in close proximity. The Division of Social Services should continue to work with counties to clarify and interpret cross county policy in the best interest of the child.

### **Division of Social Services and County Department of Social Services Supervisory Oversight**

- County DSS should encourage all agencies to call and discuss with them any case of suspected neglect. County DSS also will suggest to agency callers that the CCPT is a resource if the concern exists and it does not meet the criteria for neglect or abuse.
- On going training should be provided to social workers regarding chronic illness and medically fragile children as it relates to neglect and abuse by the Division of Social Services.
- Ongoing training should be provided to social workers regarding substance abuse risk factors and domestic violence risk factors. These risk factors should be thoroughly assessed and included in the assessment of risk and the safety assessment.
- Consistent and thorough supervision should ensure all potential victim children are identified and assessed by County DSS management.
- County DSS should utilize after-hours workers to monitor supervision of families. County DSS management should remind workers and supervisors of the importance of utilizing after hours workers.
- The local CCPT's should become more of an active resource for the interagency staffing of particularly problematic cases involved with the County Department of Social Services.
- Supervisors of County DSS blended teams should ensure that all cases are staffed a minimum of once a month. County DSS supervision should include continually evaluating whether new information should be taken as a new report for investigation. County DSS should review its agency's mission, goals and the role of supervisors in meeting these goals.
- The local DSS should ensure that a multi-level ongoing accountability and quality improvement plan is in place to assure that CPS protocols are carried out.
- County DSS supervisors should look at the quality of collateral contacts to ensure that they get the best information possible in order to ensure the protection of children.
- Team meetings should occur anytime that several agencies are involved in the same family. When County DSS is involved they should initiate meetings with various agency personnel and establish roles and responsibilities for all the workers involved with the family. This community team should see that the intervention is tailored to the client to include cultural issues. County DSS supervisors should ensure team meetings are

scheduled as appropriate. Supervisors should consider attending team meetings with inexperienced workers.

- Close attention should be paid to determining who might be able to provide objective information in which to verify parental reports.
- Legal interventions by County DSS should be evaluated when non-compliance of case plans occurs and risk factors remain present.
- It is imperative that DHHS-DSS develop a state wide tracking system for families involved in the child welfare system.

#### Medical Issues

- When a county DSS has a medical advisor on staff, staff should ensure that the medical advisor is informed of injuries to children in DSS custody and proper medical attention should be sought to examine such injuries.
- Families from rural counties may have difficulty in accessing medical care due to lack of private and public transportation and lack of medical providers.
- The North Carolina Medical Board should require training on domestic violence, to include recognition of signs and symptoms of domestic violence to their licensees. All local hospitals should provide ongoing education on how to screen for domestic violence and statutes regarding required reporting.
- The Child Service Coordination program is not fully utilized. Additional attention should be focused on ensuring nights and weekend hospital staff understands the referral process and the importance of these referrals.

#### Medical Examiner Issues

- North Carolina needs a Medical Examiner system that disseminates, distributes and applies the science and other information that exists in the central State Medical Examiner's office through every community and county requiring that information.
- A protocol should be developed by the State Medical Examiner's office and regional child abuse experts to rule out possible child abuse prior to ruling SIDS.
- The Medical Examiner's office should complete a thorough death investigation assessment which should include communicating with law enforcement and the emergency management system.
- A trained representative from the Medical Examiner's office should be present at every scene involving a child death.
- Autopsy reports and toxicology screens should be completed in a more timely fashion. Often it takes 6-8 months to receive the final report, this delay may allow for vital crime scene information to be lost.

#### Mental Health

- As a result of the 40 fatality reviews completed during this state fiscal year, it was determined that some North Carolina counties do not have access or required funding to complete parent capacity assessments.
- The Division of Mental Health, Developmental Disabilities and Substance Abuse Services should continue to assess the impact of Mental Health Reform on the availability of quality mental health services to children and their families utilizing community partners in the result outcome evaluation process.

### Parenting Education/Community Awareness

- Community awareness of the dangerous and potential tragedies should be provided regarding infants testing positive for illegal substances at birth.
- Every year, children die due to gun related incidents, therefore continued public awareness regarding gun safety and safe storage of fire arms should be provided.
- Collaboration should occur between DSS and the Health Departments to provide SIDS awareness trainings to DSS staff and the community and to support the Back to Sleep Campaign.
- A community awareness campaign of the dangers of co-sleeping should be indorsed and human service professionals trained on assessing risks and providing education to parents on appropriate sleeping arrangements for children.

### Resistant Families in Child Protective Services

- Parent- initiated placements should be used when it is a short term solution, the parent will participate and follow through with the case plan and it is not a substitute for bringing a child into custody because of safety issues especially when parents would not participate in the development or follow through with the case plan.
- Chronic neglectful parents and caretakers are a challenge for Child Protective Services and tend to drain community services of both their time and financial resources. State and local providers need a collaborated approach to efficiently utilize their resources in the most beneficial manner to the family. Human service professionals need to be equipped with specialized training in approaching chronic neglectful families and the resources to adequately serve the family to insure protection of the child and the achievement of family independence.
- The North Carolina Division of Social Services should review the utilization of safety plans as related to the legal authority to enforce them and provide guidance for county DSS agencies when the plan is not followed. Safety plans should be specific and monitored for compliance. When violation of the safety plan increases risk to the children, supervisors and workers should consult with attorneys regarding petitioning for custody.
- When a case has been opened for a Child Protective Investigative Assessment and a Safety Resource (alternative living arrangement) is still necessary because inappropriate behavior has not changed and safety issues remain if the child were to be returned to the parent, the agency should not substantiate and then close the Child Protective Investigative Assessment until that Safety Resource (alternative living arrangement) is legally secure. The local DSS should petition the court for substantiated Child Protective Services cases and request a court ordered placement when safety issues warrant a Safety Resource (alternative living arrangement).
- When agencies make a referral for a family, they should follow up with the service provider to see if the family made an appointment or kept an appointment that was made when a child's wellbeing is at stake. The agency should be clear about what the response will be when an agreed upon plan of action is not carried out by the family.
- The Division of Social Services should provide guidance to agencies in the form of specific policy, protocols and training for social workers when encountering resistant families, as this resistance in and of itself greatly elevates the risk to children.
- Kinship care assessment does not adequately reflect other children residing in the home. NCDSS should consider revising this form to account for such children.

### School Issues

- Public schools should be more proactive when it comes to attendance. In addition to attendance being important for school achievement, it is also an indicator relating to the child's health and wellbeing. The local CCPT's should hold discussions with their school systems regarding more aggressive enforcement of existing policies including any legal recourse and to better educate the community about the truancy hotline and school options for ensuring school attendance.
- The NC Office of Public Instruction should develop a centralized computer system to track school attendance and to issue an alert if children are withdrawn and not re-enrolled or record request submitted in a reasonable amount of time.
- Schools should utilize community resources when concerns do not rise to the level of abuse, neglect or dependency. School social workers should be well versed on these community resources to provide assistance to teachers in making appropriate referrals.
- Schools usually experience misbehavior/behavior disorders on an early basis and need to ensure that these behaviors are appropriately assessed to identify and evaluate potential treatment in a timely manner.
- Schools should follow procedures set forth in N.C.G.S. 115C-378 regarding the accumulation of 10 unexcused absences in a school year.

### State Child Fatality Task Force

- The Task Force should investigate other state juvenile laws that impact 16-18 year olds to determine if this age group is classified as adults when crimes are committed. Juveniles that fall into this age group are treated as adults in some respect and minors in others. It is hard to be consistent when this happens.

## Appendix B

Appendix B reflects some of the achievements reported by local communities that resulted from recommendations from State Child Fatality Reviews.

- Harnett County requested a change to the Child Health Flow Sheet form utilized by all Health Departments in North Carolina. The request was to include the assessment of bathtub/water safety as a risk factor. The North Carolina Division of Public Health accepted the revision of the form.
- Harnett County developed brochures addressing mandatory reporting laws. These brochures were distributed throughout the county. Trainings were offered to all county employees.
- Harnett County participated in a number of community awareness venue's to promote water safety for children. Several community agencies collaborated together to reach out to the community.
- Mecklenburg County has hired additional facilitators to conduct Team Decision Making meetings with families.
- Mecklenburg County completed a time study and began implementation of utilizing the court system when families are non-compliant with protection services.
- Mecklenburg County has incorporated the use of brochures on safe sleeping and SIDS during child protective services assessments.
- Mecklenburg County has provided several workshops and in-service trainings to community providers surrounding issues of domestic violence and appropriate, creative discipline for children.
- Raleigh Police Department collaborated with Interact and Safechild to sponsor a Family Violence Awareness Day in November 2004.
- A new law that requires anyone convicted of domestic violence to seek counseling and treatment went into effect in December 2004. Additionally, a new crime of assault by strangulation, a felony, was created.
- Mecklenburg County began the first town meeting in December 2004 addressing ensuring kids are healthy, safe and well-educated. This is a three year campaign.
- The N.C. Health Start Foundation and WNCU-FM were awarded a grant to start "Listen-Up – First Steps for Helping Babies". This campaign will focus on education to minorities about infant mortality.
- New Hanover County developed their Sexual Assault Response Team (S.A.R.T.) policies to allow for community collaboration.
- Cabarrus County Safe Kids, the city of Kannapolis and State Farm Insurance hosted a free children's car-seat safety check in December 2004.
- North Carolina paired with the federal government to provide asthmatics with daily air quality data that will assist in their daily planning.
- The North Carolina Professional Society on the Abuse of Children held a workshop in Charlotte on "Nearly Everything You Ever Wanted To Know About Physical Abuse".
- Owen Elementary in Charlotte, NC held classes entitled "Parenting Refresher For Grandparents".
- Caldwell County ran media campaigns in February 2005 to recruit foster parents.

- Police Officers across the state participated in “Watch Out for the Child Week” in February 2005. Officers rode in school buses to address stop arm violations. The N.C. Highway Patrol also conducted “Operation Stop Arm” which is a safety initiative to reduce collisions and fatalities involving school buses by enforcing all traffic laws around the state’s schools.
- Mecklenburg County ran public service messages in February 2005 addressing Carbon Monoxide safety.
- Gastonia police shifted to a district approach to patrolling to reduce crime.
- The Genesis Alliance in Buncombe County raised thousands for abused children in May 2005.
- Charlotte Observer in Mecklenburg County ran public service announcements in May 2005 regarding how to be a healthy mom and have a healthy baby.
- The Office of the Chief Medical Examiner began to implement the Child Death Investigation Policy across the state which allows for a consistent investigation on child deaths.
- Interact offices expanded in Wake County to provide victims of domestic violence much needed assistance. The expansion will reach fast growing communities with large minority populations and limited transportation.
- Cumberland County participated in community outreach programs to provide workshops on domestic violence.
- The Chapel-Hill Training-Outreach Program received a five-year federal grant to establish and maintain a national resource center to coordinate resources and help with training at child-abuse programs across the country.
- Senate Bill 1218 was signed by Governor Easley and became effective January 1, 2005. This bill addressed Child Passenger Safety Regulations which requires children younger than 8 years old and weighting less than 80 pounds to use some type of safety seats, including booster seats, while riding in vehicles.